Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PINE CREEK MEDICAL CENTER

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-10-1050-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
October 14, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We believe that we should get separate reimbursement for the implants, because, according to the terms of the negotiated contract, there are no restrictions in regards to implant reimbursement. The audit company is applying TDI/DWC rules when auditing this bill however; the reimbursement is made in accordance with the negotiated contract rate(s)."

Amount in Dispute: $555.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The reimbursement was based on the Maximum Allowable Reimbursement for the procedure minus the Provider's contracted discount with the Carrier. . . . The Provider is not entitled to separate reimbursement for these alleged implantables, as they are not implantables as defined by Rule 134.403(b)(2). This Rule defines implantables . . . as 'an object or device that is surgically: implanted, embedded, inserted, or otherwise applied, and related equipment necessary to operate, program and recharge the implantable." . . . The invoice appears to be for the Biomet platelet separator . . . As the platelets injected into the knee were not an 'object or device' but rather the reintroduction of the Claimant's own blood plasma, and the separator was not implanted, these invoices are not for implantables as defined by Rule 134.403(b)(2), Consequently, separate reimbursement is not due for these items . . ."

Response Submitted by: Travelers, 1501 S. MoPac Expressway, Suite A320, Austin, Texas 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2008	Outpatient Hospital Services	$555.50	$555.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - FEES – W1 – WORKERS COMPENSATION STATE F/S ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S. OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.
   - INCL – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. PACKAGED SERVICES ARE INCLUDED IN THE APC RATE.
   - IMPL – 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. NOT DOCUMENTED. INVOICE NEEDED.
   - TXGC – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. MAR AMOUNT IS GREATER THAN THE CHARGED AS PER TEXAS HOSPITAL GUIDELINES.
   - F038 – A2 – CONTRACTUAL ADJUSTMENT. ANY REDUCTION IS IN ACCORDANCE WITH FOCUS/AETNA WORKER/S COMP ACCESS LLC. FOR QUESTIONS REGARDING NETWORK REDUCTIONS, PLEASE CALL 1-800-243-2336.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. THROUGH A REVIEW OF ORIGINAL PAYMENT & ADD/L INFO RECEIVED, IT HAS BEEN DETERMINED ORIGINAL INVOICE WAS PROCESSED INCORRECTLY WHICH RESULTED IN THIS ADDITIONAL PAYMENT.
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE. THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROCEDURE BILLED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code F038 – "A2 – CONTRACTUAL ADJUSTMENT. ANY REDUCTION IS IN ACCORDANCE WITH FOCUS/AETNA WORKER/S COMP ACCESS LLC. FOR QUESTIONS REGARDING NETWORK REDUCTIONS, PLEASE CALL 1-800-243-2336." Review of the submitted information found no documentation to support that the disputed services were subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. No documentation was found of a contract between the parties to this dispute. No documentation was found of a contract between the health care provider and the alleged informal or voluntary network. No documentation was found to support that the insurance carrier, Travelers Indemnity Company, had been granted access to a contractual fee arrangement between the health care provider and the alleged network. The above payment reduction or denial reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the remarks section in box 80 of the submitted medical bill finds indication that the health care provider requested 200% reimbursement in accordance with the payment methodology specified by Division rule in 28 Texas Administrative Code §134.403(f)(1)(A). The Division therefore concludes that the health care provider did not request separate reimbursement of implantables.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 29879 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,099.88. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,079.64. The non-labor related portion is 40% of the APC rate or $733.25. The sum of the labor and non-labor related amounts is $1,812.89. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.338. This ratio multiplied by the billed charge of $2,400.00 yields a cost of $811.20. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,812.89 divided by the sum of all APC payments is 66.67%. The sum of all packaged costs is $2,798.47. The allocated portion of packaged costs is $1,865.64. This amount added to the service cost yields a total cost of $2,676.84. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $1,812.89. This amount multiplied by 200% yields a MAR of $3,625.78.
   - Procedure code 29881 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,099.88. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,079.64. The non-labor related portion is 40% of the APC rate or $733.25. The sum of the labor and non-labor related amounts is $1,812.89. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.338. This ratio multiplied by the billed charge of $2,400.00 yields a cost of $811.20. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $906.45 divided by the sum of all APC payments is 33.33%. The sum of all packaged costs is $2,798.47. The allocated portion of packaged costs is $932.83. This amount added to the service cost yields a total cost of $1,744.03. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $157.74. 50% of this amount is $78.87. The total Medicare facility specific reimbursement amount for this line, including outlier payment and multiple-procedure discount, is $985.32. This amount multiplied by 200% yields a MAR of $1,970.64.
4. The total allowable reimbursement for the services in dispute is $5,596.42. Review of the submitted information finds documentation to support payment to the requestor in the amount of $1,731.93. The requestor is seeking additional reimbursement in the amount of $555.50. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $555.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $555.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	July 18, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.